

Population Health Matters

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EDITORIAL

Quarterly Publication

Rose Colored Glasses

At year's end, I'm often asked to prognosticate about the year ahead. Recently I received a phone call from a senior consultant at Huron, a well-respected national consulting firm. He was surveying some of the usual "pundits" in our field and asked me to quickly describe the three most prominent characteristics of the healthcare system of the future.

Without hesitation, I blurted out that the health system of the future would be free of harm, recognizing that it could never be error-free. My colleague was silent, for what seemed an interminable time on the phone, until he somewhat sheepishly admitted that of the 20-plus persons he had interviewed thus far, I was the only one who provided an answer focused on safety. Never one to follow the pack, this got me more reflective about the system of the future, and hence, this editorial.

I'm going to look at the system of the future through a "rose colored lens" and hope that in the near twilight of my long career, I'll get to see such a system. The key attribute for the future should be our aspiration to become harm-free, and to fully embrace the tenets of high reliability, crew resource management, and bring into healthcare learnings from many other important industries. Our readers appreciate that leading researchers confirm that medical error is the third leading cause of death in our country; a fact which seems to have been lost on many of our elected representatives.

Other key attributes of the system of the future, through my special lens, would include a system completely focused on transparency and public accountability for outcomes. It would be characterized not

only by websites like CMS.gov, but think of CMS married to YELP and you get the idea. We need to provide millennials, who are emerging as key customers of health care, better information in a format that they are much more accustomed to. As part of this transparency, we should strive for public accountability in every aspect of care, and if it were up to me, I would mandate that error rates be publicly available on the internet on a per delivery system basis (and possibly on a per provider basis as well).

My lens predicts a completely patient-centered system, harking back to the critically important 2001 report, "Crossing the Quality Chasm." We have made only modest progress toward implementing one of the key "domains" of patient-centeredness. We need to bring the system to the patient, and this will mean fully embracing telemedicine and building new delivery systems that give patients access to the specialist in new and more convenient ways. Hardly a day goes by when I'm not stopped by bewildered patients on the street and asked directions to any one of the multiple buildings and scores of offices in our Center City location. It's truly baffling for the average consumer; just imagine trying to find a doctor's office for your follow-up visit in order to get your test results, because they're only available in-person, requiring a trip downtown, expensive parking, and other inconvenient barriers!

On the positive side, every delivery system will achieve CMS 5-star status, and we can accomplish this in part by fully embracing the notion that improvement science is central to achieving a just, patient-centered, and harm-free system. In other

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words, imagine a world where the [Central Line-Associated Bloodstream Infection](#) (CLABSI) rate is zero in every clinical setting for more than a year. Some delivery systems have achieved these remarkable results, but I'm envisioning a world where this is routine, rather than the exception.

On the educational front, I hope to see the 140 academic medical centers that form the backbone of our system implement the recommendation from [Association of Academic Medical Centers](#) (AAMC) report, [Teaching for Quality](#), and that every clinical department in every medical college has at least one faculty member with deep expertise in quality and safety. If this were to be more fully embraced, imagine its potential long-term impact! (I am proud to note that the TJU Board has unanimously approved just such a resolution and look forward to its implementation).

Every clinical department, from surgery to obstetrics and gynecology, and even psychiatry, could boast of their prowess in garnering grant support and producing peer-reviewed publications regarding quality and safety. This honestly sounds like Nirvana to me! But realistically, the far ranging impact of such a change would be enormous. These faculty would, in turn, become not only leaders in their own realm, but would serve as positive role models for thousands of medical students.

Corresponding to this sea change would be an explosion of interest in the six extant Master's degrees in healthcare quality and safety, including our [program](#) at the Jefferson College of Population Health (JCPH). The [Society for Hospital Medicine](#) (SHM) and their innovative [Quality and Safety Educators Academy](#) (QSEA), would become a standing room only affair, and would continue to help

train legions of teachers who could then carry the vision of a harm-free system to every component of the delivery system.

I believe wholeheartedly that our work today is more important than ever before. We have an opportunity to move from an admittedly "rose colored" view of the future, to a more pragmatic one by rededicating ourselves to truly cross the quality chasm, and to build a system that we can proudly pass to our children, whose future we all cherish. I hope you'll join me on this vital journey.

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Patient-Centered Outcomes for Population Health Research

American healthcare is in the midst of a *patient-centeredness* revolution. Patient-centeredness is one of the National Academy of Medicine's six aims for healthcare quality improvement,¹ and the term now infuses patient care, research, clinical organization and delivery, and policy.

On a personal note, my interest in the topic began with two coincidental encounters during my first months at Thomas Jefferson University. A woman I knew socially shared that she was undergoing breast cancer treatment and was dismayed that no one had broached the topic of sexual functioning with her. The second involved a senior physician with whom I spoke on the elevator frequently, who explained that his prostate cancer diagnosis and treatment had made his grandchildren afraid to sit on his lap. Both of these individuals were relating to me that the system had failed to ask them what was important to them as it related to potential outcomes of their care, and both encounters had a profound impact on me. If you have ever left a doctor's appointment feeling like you didn't say everything you might have, or ask all the questions you wanted to, then you might

suspect that it is difficult for some patients to clearly say exactly what is important to them. This is true in both clinical and research settings. Yet the mandate for patient-centeredness demands that we do just that: ask, listen closely, and then process the information in order for it to be useful.

In the clinical realm, definitions of patient-centeredness vary, but they do commonly mention features like 'understanding the patient as a unique person'² and 'exploring the patient's experience of illness'.³ The notion of patient-centeredness appears in discussions of *compassionate care*, *culturally appropriate care*, and *transformative care*. It is no wonder some have gone so far as to describe it as the 'magic bullet' of healthcare.⁴

In the research world, patient-centeredness is most often operationalized through patient-centered outcomes research (PCOR), which has its roots in the collaboration between social sciences and medicine, and the call for measurement of so-called 'humanistic outcomes' in the 1960's. In this era, outcomes research was born, where the possibility was raised that

outcomes could include patient experience and functioning, not just death and disease. However, research activities looking at outcomes such as quality of life or social functioning were a relatively remote pocket of research until the passage of the Affordable Care Act (ACA) when the term *patient-centeredness* was enshrined in law. The law repeatedly refers to patient-centeredness, patient satisfaction, patient experience of care, and patient engagement in its provisions.

The ACA mandated funding for comparative effectiveness research (CER), the purpose of which is "to assist consumers, clinicians, purchasers, and policy makers to make informed decisions that will improve health care at both the individual and population levels."⁵ One effect of this mandate was funding for the [Patient-Centered Outcomes Research Institute](#) (PCORI), a non-governmental body to administer CER research funding. (There is anecdotal evidence that the choice of the term 'patient-centered outcomes research institute' rather than 'comparative effectiveness research institute' was driven in part by fears in some sectors that 'comparative effectiveness' implied

rationing of treatments).⁶ Nonetheless, arguably the largest incursion of patient-centeredness into research was through the PCORI's call for the inclusion of 'patient-reported outcomes' (PROs) as endpoints in research studies. PCORI codified this in their methodology standards to guide CER.

Use patient-reported outcomes when patients or people at risk of a condition are the best source of information

(Standard PC-3)

"Measure outcomes that people representing the population of interest notice and care about." (Standard RQ-6)

PROs are defined as "any outcomes (usually questionnaire or diary-based) reported directly from patients without interpretation by health care providers."⁷ However, a reading of the history of the science of PROs reveals that their study is primarily an academic one, led by researchers and computer programmers⁸ who are making assumptions about what is important to patients, usually in the absence of patient input. Given the importance PCORI places on authentic engagement of research participants in all phases of research, my colleagues and I wanted to ask the question: *What is the best way to engage patients to identify their own important treatment outcomes?* These could be personal outcomes for use in making treatment decisions or in a clinical encounter, but we also wanted to answer a more generalizable question about patient-important endpoints to include in clinical studies.

Focus groups and individual patient interviews are the two prime methods

by which qualitative socio-medical researchers have directly elicited opinions from relevant patient stakeholders. However, for research purposes, individual interviews and focus groups are time- and labor-intensive. These methods also require some interpretation on the part of researchers as they code and analyze the qualitative results. Dr. Kristin Rising of Thomas Jefferson University's Department of Emergency Medicine had been conducting studies of this type, using interviews to elicit patients' own important outcomes for transitions of care⁹ when we began collaborating on alternate methods of allowing patients to voice their own important outcomes. The method we are testing is called 'Group Concept Mapping.'

Concept Mapping uses group brainstorming to a narrow 'prompt', and then the organization of the brainstormed material into maps based on each participant's ideas about the relatedness of the brainstormed concepts.¹⁰ It is inclusive of the ideas of all the participants in the group, and the results are driven entirely by the group without incursion of the researchers' ideas. I had already conducted a CM study to elicit patients' views on practice improvement in our primary care practice, as well as collaborated on a project with Dr. Lara Weinstein using concept mapping to investigate barriers to mammography in women with serious mental illness.¹¹ On the basis of this initial work, I suspected that concept mapping might be a good approach for eliciting patients' self-identified important outcomes.¹¹ Our project was funded by PCORI in 2015 to directly compare the patient-important

outcomes elicited by interviewing to those elicited through concept mapping. The study is called the VOICe project - Voicing Outcomes Important to Care. We are conducting the study in a population of patients with Diabetes Mellitus with the expectation that information about the methods will be generalizable to other patient populations.

Some have argued that there is a tension between 'population health' and 'patient-centeredness,'¹² namely that by focusing on individual patients we risk losing a population health focus. Our study intends to use individual patient voices to arrive at generalizable patient-important outcomes for treatment decisions that can inform both research and patient care. No one argues that knowing everything we can about the populations we serve will be important, including the outcomes that are important to individual patients within the population. This knowledge will allow us to choose appropriate endpoints for clinical studies, as well as arm clinicians with information about the patient in the room with them. We hope to show that concept mapping provides an efficient way – and truly patient-centered way – to gather this information.

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Reducing Cancer Disparities by Engaging Stakeholders (RCaDES) Initiative

First Annual Conference December 2, 2016

More than 100 attendees gathered on the Thomas Jefferson University (TJU) campus to attend the RCaDES Initiative First Annual Conference on December 2nd, 2016 and share ideas for reducing disparities in cancer screening. Ronald E. Myers, DSW, PhD (Professor of Medical Oncology at Jefferson and Director of the RCaDES Initiative), opened the meeting, and Stephen K. Klasko, MD, MBA (CEO of TJU and Jefferson Health), welcomed RCaDES' Learning Community members and invited guests. April Barry, LSW, MSW (Evaluation Manager for the Pennsylvania Department of Health, Division of Cancer Prevention and Control) and John A. Alduino, MEd (Senior Director of State Health Systems for the East Central Division, American Cancer Society) spoke about the "80% by 2018" National Campaign to raise colorectal cancer (CRC) screening rates in the United States. Both speakers highlighted the RCaDES Initiative as an important part of the effort to achieve this goal.

The RCaDES Initiative, funded jointly by the Patient Centered Outcomes Research Institute (PCORI) and Thomas Jefferson University, began in November 2015. It uses a Learning Community framework that includes a coordinating team (CT); a steering committee (SC) and patient and stakeholder advisory committees (PASACs) in two regional health systems, Jefferson Health (JH) and Lehigh Valley Health Network (LVHN). CT members include experts in cancer prevention and control research, primary care, intervention adaptation and implementation, program evaluation, IT,

and program management. SC members represent the two health systems referenced above, major private insurers in southeastern Pennsylvania, state and city public health departments, community and advocacy organizations, and employers. PASAC members include patients from racially and ethnically diverse primary care patient populations, primary care providers and specialists, and health system administrators.

In Year 1, RCaDES focused on identifying CRC screening rates among whites, African Americans, Hispanic Americans, and Asian Americans served by JH and LVHN primary care practices. In addition, a literature review was conducted to identify effective evidence-based intervention(s) that can increase CRC cancer screening adherence and reduce related disparities. Surveys were also administered to health system leaders and commercial insurer representatives to determine if they supported CRC screening programs among patients and subscribers. Moreover, health system leaders responded to a survey that included an assessment of health system readiness to implement evidence-based CRC screening interventions. Taken together, findings from these efforts showed that 1) CRC screening rates are low in the general and minority patient populations; 2) decision support and navigation intervention can increase CRC screening rates and reduce screening disparities; 3) health systems and insurers sponsor CRC screening programs; and 4) health system leaders support the implementation of evidence-based CRC screening interventions, but have concerns



Funding the Adaption and Implementation of Evidence-Based Interventions Panel. Left to right: Richard Wender, MD; Kara Odom Walker, MD, MPH, MSHS; David Chambers, DPhil, and Linda Fleisher, PhD, MPH.

about the resources required to implement such interventions and the related costs.

Linda Fleisher, PhD, MPH (Senior Researcher, Digital Health, Health Communications and Disparities, Children's Hospital of Pennsylvania) and Randa Sifri, MD (Director of Research and Director of the Faculty Development Research Fellowship in the Department of Family and Community Medicine) spoke about PASAC contributions. Accomplishments included collaboration on strategies to address issues in CRC screening through reviewing patient educational materials, conducting an analysis of the strengths, weaknesses, opportunities and threats (SWOT) for adapting a decision support and navigation intervention in their respective health systems, and expressing the need for support systems, such as multi-lingual navigators and more efficient appointment

scheduling. Melissa DiCarlo, MPH (Clinical Research Coordinator) led a discussion among SC and PASAC representatives who spoke about why they became involved in the Initiative. Representatives became involved for reasons such as having a close relative die from cancer, the desire to make screening services available to those who have limited knowledge about and access to screening services, as well as the desire to be involved in catalyzing community change. Representatives noted their appreciation of the opportunity to have their voices heard.

Following the PASAC panel, a keynote address and discussion, "The RCaDES Initiative as a Model for Addressing Cancer Screening Disparities," took place between Dr. Myers and Denise V. Rodgers, MD (Vice Chancellor for Interprofessional Programs at Rutgers Biomedical and Health Sciences, Rutgers University) and Stephen B. Thomas, PhD (Professor in the Department of Health Services Administration in the School of Public Health and Founding Director of the Maryland Center for Health Equity at the University of Maryland). Dr. Rodgers noted that while different preventive health care constituencies (e.g., health systems, insurers, employers) need to benefit from population health initiatives, the one who has the most to gain and lose is the patient. "We need to aspire to a larger social vision; we are all better when the least among us does better," she said. Dr. Thomas took the position that it is up to us to make preventive health behavior normative. "We need to include patient navigators that patients trust in health care settings, so that they and others can build trust through cultural intelligence," explained Thomas. Comments of both Dr. Rodgers and Dr. Thomas highlighted the need to find new ways for employers,



Keynote speakers: Stephen Thomas PhD, and Denise Rodgers, MD, FAAFP

insurers and health systems to work together in order to achieve equity in health care and clinical outcomes.

The first afternoon panel, moderated by Michael Rosenthal, MD (Chief, Division of Family Medicine, Acting, Department of Family Medicine and Community Health, University of Pennsylvania), was entitled "All Together Now? Health System, Insurer and Employer Support for Implementing Evidence-based Colorectal Cancer Screening Interventions." The panel was comprised of representatives from eight organizations with a variety of perspectives on the challenges we face in raising colorectal cancer screening rates (Table 1). They discussed opportunities for improvement including: developing alignment among organizations for offering screening programs to patients, community members, and employees (through insurance plans); building efficiency, cost-savings,



Evelyn Gonzales, MA (left) and Jenne' Johns, MPH (right). Colon display courtesy of Fox Chase Cancer Center.

and value with coordinated methods, communications, and messages about colorectal cancer screenings; improving reach to diverse populations by building partnerships with community-based organizations and health care agencies; and, developing collaborative efforts among insurers, health systems, and employers for implementation of cancer screening programs.

The final panel, "Funding the Adaptation and Implementation of Evidence-based Interventions," was moderated by Dr. Linda Fleisher. This panel featured experts David Chambers, DPhil (Deputy Director for Implementation Science of the Division of Cancer Control and Population Sciences, National Cancer Institute (NCI), Kara Odom Walker, MD, MPH, MSHS (Deputy Chief Science Officer, Patient-Centered Outcomes Research Institute) and Richard Wender, MD (Chief, Cancer Control Officer, American Cancer Society). The panelists' comments reinforced the importance of demonstration projects and implementation science research related to cancer screening, especially in minority populations, and highlighted potential funding options (Table 2).

The RCaDES Initiative 1st Annual Conference provided a unique opportunity for members of the Learning Community to share with each other and other attendees important information CRC screening and disparities, approaches that may be used to increase screening rates and reduce screening

Table 1: Panel Participants, "All Together Now?"
Sarah Fulton, MHS, Senior Analyst for Centers for Medicare and Medicaid Services
Frank Brown, MD, Senior Medical Director for Cigna Healthcare's Mid-Atlantic Region
Neil Goldfarb, President/CEO for the Greater Philadelphia Business Coalition on Health
Victor Caraballo, MD, MBA, Senior Medical Director for Quality Management for Independence Blue Cross
Glenn Hamilton, MD, Vice-President for AmeriHealth Caritas Family of Companies
Mitchell Kaminski, MD, Chief Clinical Officer for the Delaware Valley Accountable Care Organization
Val Slayton, MD, Medical Director for Humana
Suresh Nair, MD, Program Director for the Hematology and Medical Oncology Fellowship at Lehigh Valley Health Network.

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disparities, and obstacles and opportunities that exist to improve population health. A resounding message that emerged from this conference was, to achieve the promise of preventive health care, stakeholders must find effective ways to work together to implement evidence-based interventions in routine care.

If you are interested in learning more about the RCaDES Initiative and/or if you would like to become a member of the Learning Community, please email rcades@jefferson.edu. For more information about the RCaDES Initiative First Annual Conference, click [here](#).

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Table 2: Funding Opportunities Panel:

During the afternoon panel with Dr. Linda Fleisher, funding opportunities from the National Cancer Institute (NCI), Patient-Centered Outcomes Research Institute (PCORI) and the ACS (American Cancer Society) were discussed.

Dr. David Chambers noted the NCI's focus on implementation science, especially studying local implementation efforts to bring together teams to screen better, to learn what is working and what isn't working in local communities and how to improve practice. Dr. Chambers noted we need to make sure research makes a difference through the dissemination and implementation of research results. No matter how good the research is, if it does not impact those who need it, it is not effective.

Dr. Walker noted PCORI's interest in funding collaborations that create a pathway to bring people together, to identify innovative ways to communicate evidence that has already been generated and have people use it effectively, and to close evidence gaps.

Dr. Wender described the ACS extramural grants program which funds a wide variety of projects, including implementation research and programs that address health disparities. Many of the grants target early career investigators.

In addition, the ACS conducts a large number of cancer screening projects, most of them providing support to community health centers to promote screening. Funding for these projects comes from a variety of external foundations. The ACS welcomes the opportunity to partner with academic organizations to design and seek funding for a variety of implementation projects.

Accelerating Primary Care Transformation

There is clear consensus that a robust primary care system capable of managing the health of populations is critical to the success of our healthcare system. Yet too few clinicians enter primary care practice based on projected need,¹ and those in practice often lack key competencies to effectively manage populations. Although great strides have been made in recent years to ensure that our nationwide healthcare system is "more coordinated, quality-oriented, and patient-centered"² than ever before, development of new models to lead innovation in primary care education and practice is critical to ensure a prepared and effective primary care workforce.

A new effort to better prepare the primary care workforce is currently underway at Jefferson as an interdisciplinary team of primary care leaders in the [Department of Family & Community Medicine \(DFCM\)](#), [Division of Internal Medicine](#) and [Physician Assistant Program](#) have been awarded a five-year grant from the Health Resources and Services Administration (HRSA). Led by Principal Investigator Christine Arenson MD, Professor and Chair of the DFCM and Co-Director of the [Jefferson InterProfessional Education Center \(JCIPE\)](#), the overarching goal of

[Accelerating Primary Care Transformation at Jefferson \(JeffAPCT\)](#) is to measurably improve the health of populations served, create an exceptional experience of care, and decrease costs across our entire population, with a particular emphasis on improving outcomes and decreasing disparities for traditionally underserved segments of our population.

More specifically, our main objectives are:

- To impact Triple Aim³ outcomes through improved/expanded primary care and population health curriculum across the continuum of primary care providers and trainees
- To create enhanced, sustainable models of primary care physician faculty development that support patient-centered medical home (PCMH) transformation
- To create a new, sustainable model of faculty development for community-based primary care preceptors (MD/DO, PA, NP, others).

These are big aims, requiring unique strategies, interdisciplinary partnerships, and ongoing evaluation to adapt plans to unforeseeable events.

To ensure that these actions complement system-wide initiatives, JeffAPCT is being integrated with and fully supports ongoing clinical transformation at TJU and in member community practices. JeffAPCT will develop, implement, and evaluate new curriculum and practice transformation strategies across the full continuum of primary care education, from medical and physician assistant students through primary care residents, practitioners, and faculty. The program will facilitate effective education of the next generation of primary care providers, encourage new graduates to pursue primary care careers and prepare primary care residents with the tools necessary to support population health and PCMH. The program will also support current primary care providers and practices undertaking the hard work of practice transformation through a robust series of Practice Learning Collaboratives, an annual workshop and a secure portal to access online educational materials. These resources will support academic faculty in primary care medicine and physician assistant studies and community primary care preceptors in acquiring new skills in primary care, population health, and quality and safety to support their professional practice. Community practitioners will be provided with tools to implement "plan-

do-study-act” (PDSA) cycles and longer-term projects driven by Accountable Care Organizations (ACO) and Clinically Integrated Network (CIN) goals, pay-for-value metrics, and the needs of their individual patient populations. Additionally, JeffAPCT will create infrastructure to support enhanced recruitment of primary care clinicians from under-represented minorities, and to help recruit primary care clinicians to practice in underserved rural and urban areas.

At a year and a half into the five-year work plan, most of the initial preparation for our activities has been completed and we have made significant progress on longer-term objectives (Table 1).

The initial accomplishments outlined in Table 1 also provide a roadmap for the next few years of the grant, with a particular focus on evaluation. Our robust evaluation plan is led by Marianna LaNoue PhD, MS, Program Director for the doctoral program in Population Health Sciences at the Jefferson College of Population Health (JCPH) and Assistant Professor, DFCM, and is comprised of both process and outcomes evaluation. One example of the evaluation process from the first year of the grant was evident in the development of the leadership toolkit for residents. To ensure that plans matched the needs of the residents, Dr. LaNoue led a focus group with Family Medicine residents to better

Table 1: Initial Accomplishments toward Goals

Developed and piloted a PCMH, population health, quality and safety curriculum for students, including online training activities
Developed and piloted a toolkit to walk students through completion of a QI project
Added QI/safety projects into primary care rotations for medical and PA students
Created a primary care track in the newly established PA program
Created a leadership curriculum for primary care residents to prepare them to lead interprofessional practice improvement/transformation teams in their future practices
Supported regular meetings with primary care practices from the JeffCARE Alliance CIN as part of ongoing practice transformation/enhanced quality initiatives

understand their perceived abilities and potential barriers related to QI. Results from the focus group and concomitant survey using a modified Organizational Readiness to Change4 scale directed leadership development for Year 1; longitudinal assessment using the same scale will test impact of the toolkit.

The intended impacts of JeffAPCT are significant and require careful planning, implementation and evaluation. We are fortunate that JeffAPCT is being integrated within an academic health center and growing integrated care delivery system with a long-standing reputation for excellence in clinical care and primary care education that is rapidly transforming itself into a regional center of excellence

for population health. JeffAPCT is being led by a seasoned, diverse team of clinicians, population health experts, educators and evaluation experts with a strong record of successful innovation in primary care, population health, geriatrics, and interprofessional education. Lessons learned at Jefferson will be translated across our network of 17 regional health center educational affiliates, and will be applicable to ongoing education and care transformation nationally.

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Congratulations to the 2017 Finalists
\$100K Hearst Health Prize for Excellence in Population Health
 American Heart Association/American Stroke Association
 California Maternal Quality Care Collaborative (CMQCC) at Stanford University
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Click [here](#) to learn more about the finalists. The winner will be announced at the [17th Population Health Colloquium](#) on March 28, 2017.

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Kent Thiry, MBA, Chairman and Chief Executive Officer, DaVita Inc.



Tom Zajac, Chief Executive Officer and Business Group Leader, Population Health Management, Philips

HIGHLIGHTS:

- Announcement of the winner of the **2017 Hearst Health Prize** for Excellence in Population Health
- Three Preconference sessions
- Population Health Leaders Panel
- **Special Tuesday Night Dinner, focused on the future of clinically integrated networks**
- Presentations from top industry leaders who are revolutionizing healthcare
- **Networking opportunities**, including an Opening Night Reception featuring Hearst Health Prize finalists
- **Exhibit hall** featuring new and exciting solutions, products and services

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InterProfessional Education: A Training Ground for Population Health Leaders

"I just need to give up control," said the patient. He was a black man in his late thirties, and he was in the hospital because he had a close call with symptoms of a heart attack. He had stopped taking his medication during a time of turmoil in his life.

"That's right, let go and let God," said his friend, sitting at his bedside.

The attending physician, a petite white woman of about 35, had a different idea.

"How about if you look at it this way," she began. The entire health care team: residents, nurses, and a pharmacist, turned to look at the doctor.

"As your physician, I recommend that you take your medications. I have every reason to believe that you won't be back here anytime soon if you take your meds. But at the end of the day, it's up to you. You can choose to take your meds or not to. It's your body, and you have the right to decide what to do with it."

The patient looked puzzled for a split second, then he visibly brightened.

"You know, doctor, I think I will take my pills. I don't want to end up like this again. I can choose to do it and I'm going to do it. Thank you."

The attending said goodbye to the patient and the healthcare team followed her out.

Patient-centered care is a word that is thrown around so much that it's lost much of its meaning. Dr. Donald Berwick defined it best in his beautiful essay, "What Patient-Centered Means: Confessions of an Extremist." It is the opposite of his nightmare vision of growing old and needing hospitalization: "That's what scares me: to be made helpless before my time, to be made ignorant when I want to know, to be made to sit when I wish to stand, to be alone when I need to hold my wife's hand, to eat what I do not wish to eat, to be named what I do not wish to be named, to be told when I wish to be asked, to be awoken when I wish to sleep."¹

The attending I saw that morning, as I rounded with an internal medicine team

doing their morning rounds at the bedside, was the essence of patient-centered care. She reframed his situation, so that he was no longer a passive recipient of orders "Take your pills!" but an active caretaker of his own health. The residents learned an important lesson that day.

Patient-centered care, as we saw in this example, puts the agency with the patient, not the health care professional. Health care professionals are there to diagnose, guide, teach and advise, but at the end of the day, the patient makes the decisions. The patient's needs, not the needs of the health care provider, are what's most important in patient-centered care, and the patient, not the doctor, is the final arbiter of what his or her needs are.

I witnessed this scene because I was a student volunteer with the Jefferson Teamwork Observation Guide (JTOG) through the Jefferson Center for InterProfessional Education (JCIPE). JTOG is a validated tool for measuring observable teamwork behaviors, such as team members listening to each other and incorporating each other's input into their decision making. I accompanied Internal Medicine teams in the hospital as they did bedside rounds, then I went back to the patients and interviewed them about the teamwork behaviors they had observed. I used an iPad onto which the JTOG patient survey questions were loaded as a tool for recording patients' answers to questions about the behaviors they saw during rounds.

As an MPH student here at the Jefferson College of Population Health, I was not as experienced with the clinical environment of an acute care hospital as I was with health efforts in the community. The experience with JCIPE gave me an opportunity to reflect on how collaborative practice within the walls of the acute care facility can be a microcosm of the vision we in Population Health are trying to bring the entire healthcare system.

As I observed rounds with attending physicians, residents, nurse case managers, nurses and pharmacists all rounding as a group, I witnessed a revolution in healthcare. Though I had heard of difficult

dynamics between attending physicians and residents, Jefferson Internal Medicine physicians spoke kindly to their residents and medical students. Physicians showed respect and professionalism toward nurses, and I could see that nurses' input was critical in the team's decision making. This deep respect for each other created an environment where the patient, too, was respected. From an elderly woman on dialysis to a young man suffering from an acute attack of a chronic disease while he was away from his family at college, patients were treated with dignity and compassion. I could see the fear many of them felt melt away as they got answers to their questions, and were informed about what would happen next in their care.

What happens in the hospital affects what happens when the patient goes home. I remember a man from South Jersey struggling because he didn't know how to locate the cardiologist's office for his follow-up appointment. A nurse case manager, also from South Jersey, explained to him where he would go using landmarks he knew. That patient might have missed his follow-up appointment if the nurse case manager had not been there during interprofessional rounds to give him directions.

Working with JCIPE was an excellent opportunity for me, as a public health student, to learn about the inside of the health care system. Public Health should be considered part of the health professions, and public health students can bring a new source of energy, talent and perspective to the internal workings of the healthcare system, even in the acute care setting. I believe that public health students are an untapped resource in the academic medical center setting, and that further collaboration between public health and other health professions would be a valuable partnership for practitioners and patients alike.

Population Health is interprofessional teamwork on a grand scale: bringing together not just those inside the healthcare facility but the entire system that affects how a population lives. Breaking

Continued on page 10

down traditional silos is our mission. When every member of the healthcare team feels empowered to speak up, using his or her unique knowledge and experience to benefit the patients, we have the chance to radically improve the health of our population.

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April is a recent graduate of the MPH program at JCPH.

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Global Jefferson

I am delighted to have been selected as the first Associate Provost for Global Affairs at Thomas Jefferson University (TJU). The creation of this position underscores TJU's expanded commitment to a global agenda in education, research, and service.

There is increased recognition that health disparities occur not only in under-resourced countries, but right here in Philadelphia. Through [Jefferson's Center for Urban Health](#), its leadership in population health, its activities in supporting refugee healthcare and its ties with [Puentes de Salud](#) (Bridges of Health), serving the Hispanic community of Philadelphia, Global Jefferson continues to reaffirm support for addressing diversity in our community and to becoming an academic leader in the rapidly expanding global health arena.

TJU is not new to global health. Since the opening of TJU's international office 25 years ago under the able leadership of Janice Bogen, Assistant Vice President of International Affairs, and her staff, we have seen a continuous growth in ethnic diversity among our student body and a significant interest in increasing the opportunities for bilateral exchanges to foster learning, understanding and cultural competency.

The convening of the Committee for Global Health Initiatives 9 years ago, with representation from each of TJU's colleges, has led to the creation of education modules through the [iCE](#) (Interactive Curricula Experience) platform that will help "jump start" a planned overseas educational experience. The potential for expanding on this initiative to incorporate its use by all

global health participants, and the addition of an evaluation methodology is in the works.

In fact, TJU presently maintains 76 affiliation agreements in 31 countries. These agreements have spurred a rich history of pedagogy which has included opportunities for expansion of degree granting programs and certifications, support for seminars, lectureships, and exchanges, and an overall increase in global health research. Examples of these successful programs/exchanges are linked to academic centers in England, Israel, China, and Rwanda.

It is in this context that I bring my own NIH-funded research to the TJU family, which focuses on the leading causes of mortality and morbidity among women and newborns worldwide. With our colleagues in India and 5 other countries within the [Global Network for Women and Children's Health Research](#), we have, over the past 13 years, initiated 16 clinical trials and published 200 papers in indexed peer-review journals. We are proud to have been the first to prove and report on the effects of misoprostol to prevent postpartum hemorrhage, the leading cause of maternal mortality. Our work has been highlighted as an initiator for this lifesaving drug having been added to the [World Health Organization's List of Essential Medicines](#). The Global Network now maintains a registry of over one-half million births through 6 weeks postpartum, with follow up rates exceeding 98%, and remains a vital resource for ongoing studies.

Our newest trial, generated by our own team, will focus on preterm birth, the leading cause of neurodevelopmental childhood disability, through a large multi-country randomized, placebo-controlled trial employing the use of low-dose aspirin by consenting

nulliparous women. The study will continue for a minimum of 3 years and will add to our understanding of the pathophysiology associated with preterm birth.

Aside from maternal child health research that is anticipated to grow, there is notable research being carried out by our TJU faculty with partnerships in Japan, China, Italy, Germany, the United Kingdom, Israel, Portugal, Canada and other countries.

Our strategic vision for the future will incorporate the development of a registry to better track the important work of our education, research, and bi-directional exchanges. We will also assign additional resources to prioritize country-specific programs that will include India, Japan, China, Italy, Portugal, Israel, Rwanda, and our newest partner, St. George's University London. There have also been recent initiatives that may support specific requests from Ireland, Jordan and South Africa and some exploratory discussion on the development of a Latin American strategy.

As a component of the strategic plan, we hope to build upon the success of the long-standing Japan Center with similar initiatives in India, Italy, and China.

Despite many notable activities at our University encompassing global health, there appeared little opportunity to highlight the exceptional work of our TJU researchers and educators. In this regard, an inaugural [Global Jefferson Day](#) event was convened on January 30, 2017 with contributions from 30 speakers.

Highlighting the event were supportive comments by Jefferson's President,

Stephen Klasko, MD, MBA, and Provost, Mark Tykocinski, MD. Recent political events underscored the importance of their timely commitment to Global Jefferson. It is noteworthy that Dr. Klasko has listed expansion at Global Jefferson as among the top 5 priorities for the coming year.

Matt Baker, PA-C, DHSC, Philadelphia University's Provost, added an additional dimension to this event by reflecting on the significant international exchanges that have been a mainstay of Philadelphia University's educational mission. The opportunities to incorporate design and biomaterials into our common agenda will help to expand horizons for collaborative research.

The keynote presenter, Shivaprasad Goudar, MD, MHPE, Director of Research at our Belagavi, India site (KLE University) reinforced the importance of initial grant funding and focused on the theme of maternal child health by showing how capacity building can lead to development of a globally recognized body of work.

It is my hope that Global Jefferson Day will become an annual event providing opportunity for students and faculty to both share their contributions and inform meaningful future academic collaborations.

While education and research will always remain central themes, we will also be

exploring the opportunity to initiate distance learning, telehealth, and 2nd opinion programs and to better include representation from our local community in these exciting areas of Jefferson growth, through GLOBAL JEFFERSON.

Richard Derman, MD, MPH, FACOG

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*To view presentations from Global
Jefferson Day visit: [JDC.Jefferson.edu/
globaljeffersonday/2017/](http://JDC.Jefferson.edu/globaljeffersonday/2017/)*

POPULATION HEALTH FORUMS

A Regional Community Asset to Facilitate Collaboration and Innovation

Martin Lupinetti

*Executive Director, Healthcare Exchange of
Southeastern Pennsylvania, Inc.
October 19, 2016*

The Healthcare Exchange of Southeastern Pennsylvania (HSX) is a non-profit, independent health information exchange (HIE) organization serving the greater Philadelphia region with a mission of providing secure access to health information to enable preventive and cost effective care; improve the quality of care; and facilitate the transition of care. Martin Lupinetti, executive director of HSX, presented at the October Forum and described the many impressive activities of the organization. Mr. Lupinetti oversees the process of connecting points of care in the region, by enabling the secure sharing of patient information to make medical services more informed and efficient. Prior to this role he was a Principal and Public Sector Lead with the North Highland Company.

Mr. Lupinetti began by describing the role of HSX as a 'convener' for change in healthcare. He outlined the drivers for change such as the number of hospitals and physicians in the area; the specialist-to-primary care ratio; shift toward pay-for-performance; fewer federal grants; and minimal technology integration. He emphasized the impact of gaps in care and explored the transitions of care (TOC) challenges identified by the The Healthcare Improvement Foundation's (HCIF) PAVE project. He also pointed out that there are numerous shared savings

models, private exchanges, and readmissions challenges that drive the need for change. Patients are seen by over 9,000 unique providers in the region. HSX built a business plan emphasizing transitions of care, with a focus on what is right for the patients. HSX's founding membership includes over 37 acute care hospitals, 64 ambulatory care practices (including FQHCs), and many health plans including behavioral health organizations, and long-term care organizations.

Lupinetti went on to explain the roadmap of HSX services, which include: Direct Secure Messaging; Encounter Notification Services (ENS); clinical activity history use case and Clinical Data Repository (CDR), which Lupinetti identifies as the "next big value-add." One of the components of Direct Secure Messaging is Automated Care Team Finder (ACTF). This leverages payer information to identify a patient's primary care provider (PCP) and routes members' discharge information to those PCPs using Direct Secure Messaging. ENS is a popular subscription service that involves requested patient emergency and inpatient admits, and discharges sent to participants in real-time or as a summary list. Lupinetti described this as an encounter alerting system serving close to 2.5 million patients in the area.

Lupinetti defined engagement as capturing the attention and interest of HSX uses and aligning users with the nature of and value of Health Information Exchange. It also involves generating user participation in

HSX by reinforcing the need for clinical data. Adoption is focused on the integration of HIE functionality into the workflow.

"We're just starting the population health conversation and we need your help," states Lupinetti. He then described many potential benefits and opportunities within HSX activities. For example, he believes the CDR provides an opportunity to use patient health data to measure disease prevalence and effectiveness of medications and screenings. ENS enables providers to see how frequently their patients are admitted and discharged to area hospitals and emergency departments.

HSX's current involvement in population health includes: the Population Health Improvement Collaborative (PHIC); the North Philadelphia Accountable Community Advisory Board (ACH); the Health Enterprise Zone Initiative (HEZ); and the Health Care Innovation Collaborative. Future involvement will include organizations such as the Philadelphia Department of Public Health; Public Health Reporting; PENN Medicine's Radiology Initiative; The Children's Hospital of Philadelphia (CHOP); and Alpine Home Care.

Future plans for HSX include the establishment of a work group on population health that reports to the clinical advisory committee to guide and shape HSX's role in population health. HSX would also like to develop a population health use case and a policy infrastructure for population health initiatives.

CPR Ready: Educating and Empowering To Improve Sudden Cardiac Arrest Survival in Philadelphia

Erik D. Muther

*Director, Pennsylvania Health Care Quality Alliance
November 9, 2016*

Eric Muther is the managing director of the [Pennsylvania Health Care Quality Alliance](#) (PHCQA), a multi-stakeholder initiative of the [Health Care Improvement Foundation](#) (HCIF). Mr. Muther has worked in health care for over 19 years leading a wide range of performance measurement, quality improvement, and public health initiatives. Mr. Muther is also the program director for CPR Ready, a regional awareness and training program to improve survival rates for people who experience out-of-hospital cardiac arrest. [CPR Ready](#) was the focus of this presentation.

Mr. Muther laid the foundation by providing an overview and description of a cardiac arrest and its public health burden. A cardiac arrest occurs when the heart stops beating abruptly, without warning, and the person is unconscious with a loss of pulse. Muther states that there are over 359,000 cases of out-of-hospital cardiac arrest across the U.S. with a low survival rate. Although there can be some risk factors, in most cases there are no known risks, no history, and often no symptoms.

Muther went on to explain some startling facts: 7 out of 10 Americans feel helpless to act during a cardiac emergency because they don't know CPR, or are afraid of hurting the victim; in Philadelphia, 20.3% of people

received bystander CPR in 2015 compared to the national average of 40.6%. Muther emphasized time as the critical factor – chances of survival decrease 7-10% for every minute without bystander CPR.

Barriers to bystander CPR cover a range of issues and circumstances. In addition to the fear of causing harm, bystanders are afraid of contracting infectious disease (i.e. mouth to mouth contact). Bystanders may panic or be overwhelmed by the complexity of the tasks.

Researchers have discovered that rescue breathing isn't necessary in most situations and therefore, [Hands-Only CPR](#) may serve as a practical method to reduce barriers for bystanders to act. It simply involves calling 911 and pushing hard and fast in the center of the chest – about 100 times per minute. Survival might be better as compared to traditional CPR because it is easier to remember and increased pressure in the chest decreases blood return to the heart. There are, of course, circumstances where it is preferable to use traditional CPR such as obvious breathing problems; children under 8 years of age; electrocution; and blunt trauma.

Muther shared an overview of various training methodologies and interventions, but he was particularly excited about [PulsePoint](#), a mobile app that alerts CPR-trained bystanders to someone nearby having a sudden cardiac arrest that may require CPR. The app is activated by the local public safety

communications center simultaneously with the dispatch of local fire and EMS resources. This technology aims to reduce collapse-to-CPR times by increasing citizen awareness of cardiac events beyond a traditional “witnessed” area. It also reduces collapse-to-defibrillation times by increasing awareness of public access to automatic external defibrillator (AED) locations through real-time mapping of nearby devices.

Muther also discussed crowdsourcing as a great way to collect lifesaving AED location information. For example, applying game mechanics and design techniques to engage and motivate citizens to become more aware of AEDs in their communities. Gamification may include concepts of contests, achievements, and leaderboards for tasks such as adding AEDs or demonstrating knowledge of AED use.

In summary, this 3-year multi-stakeholder regional effort aimed at improving the outcomes of individuals suffering from out-of-hospital cardiac arrest is built on coordinating, energizing, and expanding existing resuscitative resources. Launched by the Philadelphia Regional CPR Awareness Coalition, it aims to double the number of people trained in CPR/AED in the Philadelphia region, and triple the bystander response rate. Additionally, there is a focus on ensuring that CPR/AED education is taught in at least half of the middle and high schools by 2019.

Positioning Physician Practices to Deliver High-Value: The Interface of Primary Care and Specialty Care

Scott Shipman, MD, MPH

*Director of Primary Care Initiatives and Workforce Analysis
American Association of Medical Colleges*

December 14, 2016

The December Forum featured Scott Shipman, MD, MPH, director of primary care initiatives and workforce analysis at the [American Association of Medical Colleges](#) (AAMC). Dr. Shipman coordinates primary care activities across the AAMC, where he works with a wide range of primary care leaders to enhance, promote, and

disseminate effective innovations in teaching and delivery of primary care. He guides AAMC activities that promote the role of primary care in emerging high-value ambulatory care models. He is a general pediatrician and health services researcher by training.

Dr. Shipman is particularly interested in referrals to specialists from primary care providers (PCPs). He opened the session by sharing hypothetical examples of referred cases. Common threads and problems include: communication gaps, repeated tests, specialist referral to another specialist, fragmentation, and “no one serving as the quarterback.” Dr. Shipman explained that 1 in 3 patients

is referred to a specialist each year and this number increases for patients over the age of 65. Referral volumes have doubled in the past decade and as of 2013 more office visits have occurred with specialists than with PCPs.

Dr. Shipman asked the audience, “Why have referrals become so much more prevalent?” The discussion covered a number of reasons including: increased supply of specialists and patient drivers (i.e. public information, patient demand, patient expectations, perceptions regarding technology). Fee-for-service payment and limited time during visits to take on complex conditions also contribute to this situation. The expansion of increasingly

specialized clinical care creates challenges for the PCP. The referral process itself also tends to be inefficient.

“Why should we care about this notion of communication, coordination and community between providers?” asks Shipman. “At the heart of this, it comes down to fragmentation... care that is fragmented is care that is sub-optimal,” states Shipman. It is a negative on quality and it drives up costs. The emphasis on maximizing quality for costs is critical in healthcare today.

One initiative designed to address these issues is [Project CORE](#) – Coordinating Optimal Referral Experiences. With funding from the [CMS Innovation Center](#) and support from the University of California, San Francisco, AAMC convened five academic medical centers to implement this model. The elements of the CORE model include: improved communication, coordination, access, clinical alignment, and culture. The model is designed to improve specialty access, enhance primary care comprehensiveness, reduce unwarranted variation in referral, improve quality and convenience for patients and control costs.

As part of the model, an enhanced referral system with various templates (including a specific set of questions) was designed and incorporated into the EMR. Also developed was decision support for the PCP that helps with communication around testing. The CORE model helps to set and standardize guidelines for when the referral is appropriate. For example, identifying things that may need to be done before the referral is built into the decision support tool.

Another component of the enhanced referral system, eConsult is a tool that enables an asynchronous exchange between the PCP and the specialist. For example, a PCP may be able to manage a particular problem with some guidance or support from the specialist.

Dr. Shipman discussed some of the results of the CORE model. University of California, San Francisco (UCSF), which was the first institution to participate, saw some early promising results. An increase in access to specialty care was seen within the first 14 days of the intervention period. They also saw an increase in external referrals and experienced a decrease in ED visits. As for the other four institutions, eConsult results reveal an increase in provider and

specialist satisfaction. For all five sites, there is increased use of eConsult.

The benefits of eConsult to the patient are timely access to personalized specialty input, continuity with a familiar provider and setting, and avoidance of having to re-explain a medical history to a new provider. It is important to mention that if a specialist visit is preferred or deemed necessary it is still possible to receive the referral.

Shipman explains that eConsult alone will not address the spectrum of gaps in quality and efficiency of the interface between the PCP and the specialist. Paying for an eConsult is an ongoing battle, and if specialists have a meager demand, they may avoid using eConsult.

The presentation was summarized by discussing the scalability and sustainability of the CORE model. Future steps will include convening a third cohort of participants, expansion at current sites, and extension to other care settings. AAMC plans to work with CMS on a reimbursement and sustainable payment model.

To view slides and listen to audio recordings of Population Health Forums visit:
JDC.Jefferson.edu/hpforum/

Community Driven Research Day

[Community Driven Research Day](#) (CDRD) is an annual event that provides an opportunity for community based organizations to discuss their research needs with researchers from five sponsoring academic institutions, including Jefferson, Temple University, University of Pennsylvania, The Children’s Hospital of Philadelphia, and Drexel University, in a conference-style format with poster presentations that outline community-based projects.

For 2015-2016, JCPH provided support for Philadelphia Interfaith Hospitality Network’s project to identify common characteristics of programmatic success and health among

the homeless families that they serve. They are currently working with Dr. Rickie Brawer and Dr. Jim Plumb on this assessment, and are utilizing Jefferson students to do secondary data analyses and, eventually, interviews with families.

On December 7, 2016, JCPH and the Jefferson College of Nursing hosted the 2016-2017 CDRD, “Novel Approaches to Community Health Promotion.” At the event, 23 representatives from community organizations display posters about their organization and services, and spoke with over 100 attendees, including faculty, students, and community members.

Following CDRD is a Call for Proposals, whereby community based organizations can work with researchers from one of the sponsor institutions on an application for funding for a CBPR project. Each sponsor institution receives proposals from community members who want to work with their faculty, and then choose at least one project to fund.

Click [here](#) for more information.

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JCPH Alum Kate Fox, MPH at Community Research Day representing Community Behavioral Health.



IN THE NEWS



April Smith with Dr. Simmons and Dr. Padron at APHA Annual Meeting 2016.



General Colin Powell and The Dean



Dr. Baxter presenting at the Patient Safety Clerkship.



JCPH welcomes Assistant Professor Jillian Baker, DrPH, seen here at a conference in Barcelona.



Dr. Katherine Schneider spoke at the Population Health Forum in January.



JCPH Alum Tara Ketterer, MPH with Dr. Simmons at APHA Annual Meeting 2016.



* Aaron Snider presenting his MS Health Policy capstone, "Exploring Policy Options for Increasing Charity/Uncompensated Care Funding while Potentially Reducing Inappropriate Firearm Usage."



* Alexis Silverio presenting her MPH capstone, "Evaluating the Effectiveness of a Health Promotion Intervention in an Urban Population Regarding Stair Utilization."



Healthcare Quality and Safety Capstones were presented at American Association for Physician Leaders. Front row left to right: Cheryl McLain MD and Judith DeJarnette, MD. Back row left right: Sheryl Williams, MD, and Bryan Burns, DO.

* JCPH Capstone presentations can be found on Jefferson Digital Commons by degree program: JDC.Jefferson.edu/jcph

UPCOMING JCPH FORUMS

March 8, 2017

Implementation Science from Research to Practice

Linda Fleisher, PhD, MPH

Senior Scientist, The Center for Injury Prevention Research and Prevention
Children's Hospital of Philadelphia

Bluemle Life Sciences Building, Room 105/107

April 12, 2017*

Medicare at 50: Its Effect on Disparities

Edith P. Mitchell, MD, FACP

Clinical Professor of Medicine and Medical Oncology
Department of Medical Oncology
Director, Center to Eliminate Cancer Disparities
Associate Director, Diversity Affairs
Sidney Kimmel Cancer Center at Jefferson

Bluemle Life Sciences Building, Room 105/107

*This forum will be followed by a special Grandon Society member-only session with Dr. Mitchell from 9:45 am – 10:30 am.

Forums take place from 8:30 am - 9:30 am and are free of charge. Forums are designed for Jefferson students, faculty and staff; health care professionals, administrators, public policy analysts, advocates, and community health leaders. For more information visit: Jefferson.edu/PopHealthForum

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Cooper MR. Partnering to change perinatal care: moving from a duet to a chorus. Presented at: Fourth Annual Conference, Evolving Trends in Perinatal Nursing Conquering Interprofessional Communication, Yale University, November 3, 2016, Orange CT.

Zeigler-Johnson C, Keith SW, **McIntire RK, Leader A**, Glanz K. Local prostate cancer trends: the role of race. Presented at: 2017 Science of Global Prostate Cancer Disparities in Black Men Conference; Florida Cancer Advisory Council, November 2016, Orlando, FL.

JCPH AT APHA 2016 MEETING

Brawer R, Plumb J. Integrating community health needs assessment into program planning and evaluation: an experiential learning approach.

Cohen C. Hepatitis B knowledge and beliefs among cohorts in China and Philadelphia: implications for addressing the burden of chronic HBV infection.

Cohen C. Hepatitis B screening and prevention among high-risk populations.

Cohen C. Hepatitis B education, prevention, and screening in Philadelphia through APAMSA outreach.

Harmon M, **Pilling L**, Johnson R, Hicks V, Joyce B, Brown-Schott N. Transforming the application of public health nursing competencies.

Leader A. Enhancing a qualitative research methods course with experiential learning.

McIntire RK. Observed smoking behavior: a field-based project to teach practical epidemiological skills.

Simmons R, Romney M. The benefits of experiential education in public health education: practice examples in introduction to public health and advocacy courses.



Dr. McIntire at the podium. Panel left to right: James Plumb, MD, MPH; Rickie Brawer, PhD, MPH, CHES; and Amy Leader, DrPH, MPH

Population Health *Matters*

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